Employee Benefit Plan Enrollment

FOR NEW EMPLOYEES AND THOSE WITH A QUALIFYING LIFE EVENT ONLY

MONTGOMERY COUNTY PUBLIC SCHOOLS Maryland CLEAR FORM

Employee and Retiree Service Center (ERSC) • Rockville, Maryland
MONTGOMERY COUNTY PUBLIC SCHOOLS

INSTRUCTIONS: Complete both sides, sign, and return to the Employee and Retiree Service Center (ERSC). This form must be signed at the bottom of pages 1 and 2. You may fax enrollment forms to 301-279-3642/301-279-3651 or email an electronically signed Adobe PDF to ERSC@mcpsmd.org. Please do not mail copies to ERSC once you have faxed or emailed the enrollment form. A confirmation of your requested change(s) will be sent to you. Unsigned forms will be returned to you and will become your responsibility to resubmit to ERSC by the appropriate deadline. Please see the *Employee Benefit Summary* (EBS) for deadline information.

SECTION I: EMPLOYEE INFORMATION—Please print.

Name _____ Employee ID #_____

Last Four Digits of SSN # ___ ___ ___ ___ Home Phone #____-____-_____ Work Phone #____-____-_____

Work Location _____ Date of Birth____/____/_____

Is your spouse or dependent(s) covered under their own MCPS plan? ❑ Yes ❑ No Spouse/dependent employee ID# _____

(***Please note:*** MCPS employees or dependents may only be covered under one MCPS plan.)

SECTION II: ENROLLMENT INFORMATION—If your address has changed, please visit the Employee Self-Service web page at *www2.montgomeryschoolsmd.org/departments/ersc/employees/employee-self-service/* to update it.

❑ **Individual** ❑ **Two-Party** ❑ **Family**

A. Form Submission Reason

❑ New Employee *(revisions only)*

❑ Qualifying Life Event
Please include application documentation

❑ Cancel coverage while on leave effective ____/____/_____
(Date of cancellation must adhere to deadline rules in EBS.)

❑ Employees Returning from Leave *(must reenroll in same plan prior to leave within 60 days of return)*

C. Drop Dependents

❑ Child* effective ____/____/_____

❑ Spouse* effective ____/____/_____

D. Enroll Dependent(s) **Date**

❑ Marriage* ____/____/_____

❑ Birth of Child* ____/____/_____

❑ Adoption of Child* ____/____/_____

❑ Stepchild*,** ____/____/_____

❑ Other Explain: _____

_____

_____

B. Action

❑ I ***decline/cancel*** all benefit plan enrollment effective ____/____/_____
—skip to **Section V, Employee Life Insurance**

❑ Change of Beneficiary only—skip to **Section VI, Life Insurance Beneficiary Designation**

❑ Add/Drop Dependent (complete Sections IIC, IID, and IV)

*You must attach legal documentation (i.e., birth or marriage certificate, social security number, if applicable).

**For additional requirements, please review the *Employee Benefit Summary*.

SECTION III: BENEFIT PLAN ENROLLMENT—You must make a selection in each category (A–D).

CATEGORY A (Medical Plans)—Please select one.

❑ I ***decline*** medical coverage

❑ No change to medical plan

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

❑ Cigna Open Access Plus in-Network (OAPIN)

❑ Kaiser Permanente

OPEN POINT-OF-SERVICE (POS) PLAN

❑ Cigna Open Access Plus (OAP)

CATEGORY B (Prescription Drug Plans)—Please select one.

❑ I ***decline*** prescription drug coverage

❑ No change to prescription drug plan

❑ Caremark (available to all employees **except** Kaiser HMO members)

❑ Kaiser (**only** available to Kaiser HMO members)

CATEGORY C (Dental Plans)—Please select one.

❑ I ***decline*** dental coverage

❑ No change to dental plan

❑ CareFirst Preferred Provider Organization (PPO)

❑ Aetna Dental Maintenance Organization (DMO) (must reside in a DMO service area.)

CATEGORY D (Vision Plan)—Please select one.

❑ I ***decline*** vision coverage

❑ No change to vision plan

❑ Davis Vision (provided through CareFirst)

I understand that my electronic submission of this form and my electronic signature are intended to be, constitute, and are equivalent to my personal signature.

SIGNATURE REQUIRED on pages 1 and 2_____ Date ____/____/_____

(continue on reverse side)

SECTION IV: COVERED PARTICIPANTS—Your dependent(s).

List: ❑ All new participant(s) **OR** ❑ All added or dropped dependent(s). List additional dependents on an attached blank form. **Please include a copy of a marriage certificate (when enrolling a spouse) or birth certificate/birth registration (when enrolling a child).** Additional requirements are available in the *Employee Benefit Summary*.

First Name	Last Name	MI	Social Security # **(must be included)**	Date of Birth	Sex	Add/Drop
Spouse						❑ / ❑
Child						❑ / ❑
Child						❑ / ❑
Child						❑ / ❑
Child						❑ / ❑

SECTION V: BASIC EMPLOYEE TERM LIFE INSURANCE ENROLLMENT

❑ I want to ***re-enroll*** in Basic Term Life Insurance coverage *(evidence of insurability required)*
❑ I ***decline*** all Life Insurance coverage
❑ Change of Beneficiary
❑ No Change

SECTION VI: LIFE INSURANCE BENEFICIARY DESIGNATION

Please check Primary or Contingent for each designated beneficiary. If neither box is checked, the named beneficiary will be deemed as a primary beneficiary.

❑ No Change ❑ Change of Beneficiary

- Benefits shall be divided equally among primary beneficiaries (or contingent beneficiaries), unless otherwise stated.
- The contingent beneficiary(ies) shall be entitled to life insurance benefits in the event there is no surviving primary beneficiary.
- If designating a Trust as a beneficiary, please provide a copy of the title, trustee, address, and signature pages of the Trust.

❑ Primary

Name _____

Address _____

Share _____% Relationship _____

❑ Primary ❑ Contingent

Name _____

Address _____

Share _____% Relationship _____

❑ Primary ❑ Contingent

Name _____

Address _____

Share _____% Relationship _____

FOR ADDITIONAL BENEFICIARIES OR COVERED PARTICIPANTS, PLEASE ATTACH AN ADDITIONAL BLANK FORM.

Name _____ Employee ID # _____

I understand that my electronic submission of this form and my electronic signature are intended to be, constitute, and are equivalent to my personal signature.

SIGNATURE REQUIRED on pages 1 and 2_____ Date ____/____/_____